me to the extent that I must pass along my appreciation.

The scholarship was most enjoyable, certainly, but the insight into the human and sometimes less than normally human attributes of physicians, however elevated in professional stature, was even more intriguing.

The fact that I have agreed with the article's tenets for some decades, of course, creates an even greater sense of gratification in reading the excellent prose.

Congratulations to the author on her literary and intellectual efforts.

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Psychiatric Symptoms of Neurosyphilis

TO THE EDITOR: This is regarding the article entitled "The Great Imitator, Syphilis" in the May 1981 issue.[1] All in all it was an excellent article, well written and of course very timely.

I wonder if Dr. Fitzgerald would be willing to comment a little on aspects of tertiary syphilis that we in psychiatry have to bear in mind. I believe it is a point not covered in the article.

Treatment of incidental infections with penicillin or other antibiotics will often convert the peripheral blood VDRL. The physician then, in getting either routine studies or serologic studies in suspected cases, may be lulled into a false sense of security. After the treatment of the incidental infection and the conversion to seronegative peripheral blood, is not the disease then permitted to continue, often not surfacing until the tertiary stage? Would Dr. Fitzgerald perhaps have some helpful hints on how to make a diagnosis of paresis in such a case?

Recently I became sensitized to such a case. The patient was a 59-year-old Puerto Rican man of Carribe extraction. Clinically he presented as a paretic. The VDRL peripherally was negative and it was only when clinical evidence forced me to do a lumbar puncture and an FTA-ABS (fluorescent treponemal antibody absorption test), which turned out positive, that we were able to make a diagnosis and initiate treatment.

With the ever-increasing use of antibiotics to treat minor illnesses and with the increasing incidence of venereal disease in general and syphilis in particular, is not this a danger that we are overlooking?

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REFERENCE

1. Fitzgerald F: The great imitator, syphilis—Medical Staff Conference, University of California, San Francisco. West J Med 134: 424-432, May 1981

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The Author Replies

TO THE EDITOR: Dr. Stubblebine raises a most important point. Syphilis at one time was said to account for 10 percent to 20 percent of admissions to state mental hospitals.[1] Though this is no longer the case, syphilis must still be considered in the differential diagnosis of almost every mental disease. As Dr. Stubblebine implies, antibiotic therapy may have altered the classical clinical patterns of neurosyphilis.[2] Though it is generally accepted that antibiotic therapy which leads to reversion to seronegativity in early syphilis constitutes a "cure,"[3-5] two unresolved issues confound absolute surety on this point. First, of course, is that spontaneous reversion to seronegativity is common even in *untreated* lues, and a quarter to a half of all patients with late syphilis will have a negative serum VDRL.[2,6] In one study, only 48.5 percent of neurosyphilitic patients—some of whom gave a history of previous therapy for syphilis—had reactive serologic tests for syphilis.[2] The second issue to be considered touches upon the data which suggest the persistence of spirochetes in central nervous system (CNS) tissue in spite of putatively adequate penicillin therapy and negative serum VDRL.[6]

It is best to rely, as did Dr. Stubblebine, on clinical clues. Psychiatrists might well be the first physicians consulted by the victims of neurosyphilis. Meningovascular syphilis may simulate psychoneurosis,[1] as the rare gummatous mass in the CNS can look like a brain tumor and induce personality changes. In a study of more than 200 patients with CNS lues in the penicillin era, about 9 percent had "organic brain syndrome," 5 percent depression, 3 percent mania and 2 percent other personality changes.[2]

The onset of the psychiatric symptoms of general paresis can be insidious, first noticed by family and friends rather than the patient: loss of ambition at work, memory lapses, irritability and a decline in attention to personal affairs. Later, patients may present with mental changes simulating schizophrenia, euphoric mania, paranoia, toxic psychoses or presenile dementias. The last is most common, with depression, confusion and severe impairment of memory and judgment. In the last stages of the disease, occurring generally within five years of the onset of symptoms, almost